METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PROSPECTIVE REIMBURSEMENT SYSTEM FOR LONG TERM CARE FACILITIES

STATE PLAN AMENDMENT 4.19-D

I. General Provisions

A. Purpose

This plan establishes a reimbursement system for long-term care facilities that complies with federal requirements, including but not limited to:

- Requirements of the Omnibus Reconciliation Act of 1981 that nursing facility provider reimbursements be reasonable and adequate to assure an efficient and economically operated facility.

- The requirement that Medicaid payments in the aggregate do not exceed what would have been paid by Medicare based on allowable cost principles.

- Limitations on the revaluation of assets subsequent to a change of ownership since July 18, 1984.

- Requirements of the Omnibus Reconciliation Act of 1987 to establish one level of nursing care, i.e., Nursing Facility Care, to eliminate the designation of Skilled and Intermediate Care, and to provide sufficient staff to meet these requirements.

- The requirement to employ only nurse aides who have successfully completed a training and competency evaluation program or a competency evaluation program.

B. Reimbursement Principles

1. Providers of nursing facility care shall be reimbursed prospectively determined per diem rates based on a patient based classification system. Providers of ICF-MR and ICF-IMD services shall be reimbursed prospectively determined per diem rates.

2. The Delaware Medicaid Program shall reimburse qualified providers of long-term care based on the individual Medicaid recipient's days of care multiplied by the applicable per diem rate for that patient's classification less any payments made by recipients or third parties.

II. Rate Determination for Nursing Facilities

A. Basis for Reimbursement

Per Diem reimbursement for nursing facility services shall be composed of five prospectively determined rate components that reimburse providers for primary patient care, secondary patient care, support services, administration, and capital costs.

The primary patient care component of the per diem rate is based on the nursing care costs related specifically to each patient's classification. In addition to assignment to case mix classifications, patients may qualify for supplementary primary care reimbursement based on their characteristics and special service needs. Primary care component reimbursement for each basic patient classification will be the same for each facility within a group. A schedule of primary rates, including rate additions, is established for each of three groups of facilities:

- Private facilities in New Castle County
- Private facilities in Kent and Sussex Counties
- Public facilities

Payment for the secondary, support, administrative, and capital costs comprise the base rate, and is unique to each facility. Provider costs are reported annually to Medicaid and are used to establish rate ceilings for the secondary, support, and administrative cost centers in each provider group.

The sections that follow provide specific details on rate computation for each of the five rate components.

B. Rate Components

Payment for services is based on the sum of five rate components. The rate components are defined as:

- **Primary Patient Care.** This cost center encompasses all costs that are involved in the provision of basic nursing care for nursing home patients and is inclusive of nursing staff salaries, fringe benefits, and training costs. Costs of completing Resident Assessment and Plans of Care will be covered in this cost center.

- **Secondary Patient Care.** This cost center encompasses other patient care costs that directly affect patient health status and quality of care and is inclusive of clinical consultants, social services, raw food, medical supplies, and non prescription drugs, dietitian services, dental services, and activities personnel.

- **Support Services.** This cost center includes costs for departments that provide supportive services other than medical care and is inclusive of dietary, operation and maintenance of the facility, housekeeping, laundry and linen, and patient recreation.

- **Administrative.** This category includes costs that are not patient related and is inclusive of owner/administrator salary, medical and nursing director salary (excluding such time spent in direct patient care), administrative salaries, medical records, working capital, benefits associated with administrative personnel, home office expenses, management of resident personal funds, and monitoring and resolving patient's rights issues.

- **Capital.** This category includes costs related to the purchase and lease of property, plant and equipment and is inclusive of lease costs, mortgage interest, property taxes and depreciation.

C. Excluded Services

Those services to residents of private long term care facilities that are ordinarily billed directly by practitioners will continue to be billed separately and are not covered by the rate component categories. This includes prescription drugs, Medicare Part B covered services, physician services, hospitalization and dental services, laboratory, radiology, and certain ancillary therapies.

For public facilities, laboratory, radiology, prescription drugs, physician services, dental services, and ancillary therapies are included in the per diem.

Costs of training and certification of nurse aides are billed separately by the facilities as they are incurred, and reimbursed directly by Medicaid.

D. Primary Payment Component Computations

The primary patient care rate component is based on a patient index system in which all nursing home patients are classified into patient classes. The lowest resource intensive clients are placed in the lowest class.

The Department will assign classes to nursing home patients. Initial classification of patients occurs through the State's pre-admission screening program. These initial classifications will be reviewed by Department nurses within 31 to 45 days after assignment. Patient classification will then be reviewed on an ongoing 90-day basis. Facilities will receive notices from the Department concerning class changes and relevant effective dates.

1. In order to establish the patient classification for reimbursement, patients are evaluated and scored by Medicaid review nurses according to the specific amount of staff assistance needed in Activity of Daily Living (ADL) dependency areas. These include Bathing, Eating, Mobility/Transfer/Toileting. Potential scores are as follows:

   0 - Independent
   1 - Supervision (includes verbal cueing and occasional staff standby)
   2 - Moderate assistance (requires staff standby/physical presence)
   3 - Maximum Assistance

   Patients receiving moderate or maximum assistance will be considered "dependent" in that ADL area. Patients receiving supervision will not be considered dependent.

   Reimbursement is determined by assigning the patient to a patient classifications based on their ADL scores or range of scores.

   Each patient classification is related to specific nursing time requirements determined by the time and motion study last updated in 1991. These time factors are multiplied by the median nurse wage in each provider group to determine the per diem rate for each classification.

2. Patients receiving an active rehabilitative/preventive program as defined and approved by the Department shall be reimbursed at the next higher patient class. For qualifying patients at the highest level, the facility will receive an additional 10 percent of the primary care rate component.

   To be considered for the added reimbursement allowed under this provision, a facility must develop and prepare an individual rehabilitative/preventive care plan. This plan of care must contain rehabilitative/preventive care programs as described in a Department approved list of programs. The services must seek to address specific activity of daily living and other functional problems of the patient. The care plan must also indicate specific six month and one-year patient goals, and must have a physician's approval.

The Department will evaluate new facility-developed rehabilitative/preventive care plans during its patient classification reviews of nursing homes.

Interim provisional approval of plans can be provided by Department review nurses. When reviewed, the Department will examine facility documentation on the provision of rehabilitative/preventive services to patients with previously approved care plans as well as progress towards patient goals.

3. Patients exhibiting disruptive psycho social behaviors on a frequent basis as defined and classified by the Department shall receive an additional 10 percent of the primary care rate component for the appropriate classification.

   The specific psycho social behaviors that will be considered for added reimbursement under this provision are those that necessitate additional nursing staff intervention in the provision of personal and nursing care. Such behaviors include: verbal and physically disruptive actions, inappropriate social behavior, non-territorial wandering, and any other similar patient problems as designated by the Department.

   Facilities must have complete documentation on frequency of such behaviors in a patient's chart for the Department to consider the facility for added reimbursement under this provision. This documentation will be evaluated during patient classification reviews of a nursing home.

4. Patient class rates are determined based on the time required to care for patients in each classification, and nursing wage, fringe benefit, and training costs tabulated separately for private facilities in New Castle County, private facilities in Kent and Sussex Counties, and public facilities statewide.

   Primary rates are established by the following methodology

   - Annual wage surveys and cost reports required of each provider are used to determine median hourly nursing wages.

     The cost report used in the calculations will represent the fiscal year ending June 30th of the previous reimbursement year. The Delaware reimbursement year, for purposes of rate setting, is from October 1 through September 30.

This is calculated by first dividing total pay by total hours for each nursing classification (RN, LPN, Aide) in each facility, then arraying the averages to determine the median within each provider group. Based on cost data from each provider group, hourly wage rates are adjusted to include hourly training and fringe benefit costs within each provider group.

- In each of the three provider groups (private facilities in New Castle County, Kent and Sussex Counties, and public facilities), the rates are established in the same manner.

  The primary component of the Medicaid nursing home rate is determined by multiplying the median hourly nursing wage for RNs, LPNs, and Aides by standard nursing time factors for each of the base levels of patient acuity. The nursing time factor was determined by a 1981 Maryland work measurement study, and updated in 1987 by Peat Marwick and again in 1991 by Lewin/ICF. The time factors based on this, the most recent time and motion study, are included in the Delaware reimbursement calculation documentation.

- Providers will be reimbursed for agency nurse costs if their use of agency nurses does not exceed the allowable agency nurse cap determined each year by the Delaware Medicaid staff. Any nursing cost incurred in excess of the allowable cap will not be included in the nursing cost calculation. The caps on the agency nurse contribution to hourly nursing costs is set at the median utilization ratio of agency to staff nurse hours for those facilities that use agency nurses.

- Within each of the patient classes, Medicaid provides "Incentive add-ons" to encourage rehabilitative and preventive programs. Rehabilitative and preventive services shall be reimbursed at the same rate as the next highest patient class. In the case of patients in the highest class, the facility will receive an additional 10 percent of the primary care rate component. Incentive payments discourage the deterioration of patients into higher classifications.

E. Non-Primary Rate Component Computations

Facility rates for the four non-primary components of secondary, support, administrative, and capital are computed from annual provider cost report data on reimbursable costs. Reimbursable costs are defined to be those that are allowable based on Medicare principles, according to HIM 15. Costs applicable to services, facilities, and supplies furnished to a provider by commonly owned, controlled or related organizations shall not exceed the lower cost of comparable services purchased elsewhere.

The cost report used in the calculations will represent the fiscal year ending June 30th of the previous reimbursement year. The Delaware reimbursement year, for purposes of rate setting, is from October 1 through September 30.

The discussion that follows explains rate computation for the secondary, support, administrative, and capital payment centers.

1. Secondary patient care rates are reimbursed according to the cost of care determined prospectively up to a calculated ceiling (115 percent of median per diem costs). Three steps are required:

   - Facilities are grouped into the three peer groups - private facilities in New Castle County, private facilities in Kent and Sussex Counties, and public facilities.

   - Individual allowable cost items from cost reports for each facility comprising the secondary care component are summed and divided by patient days. For established facilities, the patient day amount used in this computation equals actual patient days or estimated days based on a 90 percent occupancy of Medicaid certified beds, whichever is greater. The day amount for new facilities* equals actual patient days for the period of operation, or estimated days based on a 75 percent occupancy of Medicaid certified beds, whichever is greater.

   - The median per diem cost is determined for each category of facility and inflated by 15 percent. The secondary care per diem assigned to a facility is the actual allowable cost up to a maximum of 115 percent of the median.

2. Support service component rates are determined in a manner that parallels the secondary component rate calculation process. However, the ceiling is set at 110 percent of median support costs per day for the appropriate category of facility. In addition, facilities which maintain costs below the cap are entitled to an incentive payment 25 percent of the difference between the facility's actual per day cost and the applicable cap, up to a maximum incentive of 5 percent of the cap amount.

*"New facility" is defined as: (1) New construction built to provide a new service of either intermediate or skilled nursing care for which the existing facility has never before been certified, or (2) construction of an entirely new facility totally and administratively independent of an existing facility.

3. Administrative component rates are determined in a manner parallel to the secondary component. However, the ceiling is set at 105 percent of median costs per day. A facility is entitled to an incentive payment of 50 percent of the difference between its actual costs and the cap. The incentive payment is limited to 10 percent of the ceiling amount.

4. Capital component rates are determined prospectively and are subject to a rate floor and rate ceiling. The dollar amounts representing the 20th percentile of actual per diem capital cost (floor) and the 80th percentile of actual per diem capital cost (ceiling) are calculated. If the facility's costs are greater than or equal to the floor, and less than or equal to the ceiling, the facility's prospective rate is equal to its actual cost. If the facility's costs are below the floor, the prospective rate is equal to the lower of the floor or actual cost plus twenty-five percent of actual cost. if the facility's cost are greater than the ceiling, the prospective rate is equal to the higher of the ceiling or ninety-five percent of actual cost. Costs associated with revaluation of assets of a facility will not be recognized.

F. Computation of Total Rate from Components

A facility's secondary, support, administrative, and capital payments will be summed and called its basic rate. The total rate for a patient is then determined by adding the primary rate for which a patient qualifies to the facility's basic rate component. The basic payment amount will not vary across patients in a nursing home. However, the primary payment will depend on a patient's class and qualification for added rehabilitative/preventive and/or psycho social reimbursement.

G. OBRA '87 Additional Costs

1. Nurse Aide Training and Certification

Providers of long-term care services will be reimbursed directly for the reasonable costs of training, competency testing and certification of nurse aides in compliance with the requirements of OBRA '87. The training and competency testing must be in a program approved by the Delaware Department of Health and Social Services, Division of Public Health. A "Statement of Reimbursement Cost of Nurse Aide Training" is submitted to the state by each facility quarterly.

Costs reported on the Statement of Reimbursement Cost are reimbursed directly and claimed by the State as administrative costs. They include:

- Costs incurred in testing and certifying currently employed nurse aides, i.e., testing fees, tuition, books, and training materials.

- Costs of providing State approved training or refresher training in preparation for competency evaluation testing to employed nurse aides who have not yet received certification.

- Salaries of in-service instructions to conduct State approved training programs for the portion of their time involved with training, or fees charged by providers of a State approved training program.

- Costs of transporting nurse aides from the nursing facility to a testing or training site.

The following costs of nurse aide training are considered operational, and will be reported annually on the Medicaid cost report. These costs will be reimbursed through the Primary cost component of the per diem rate.

- Salaries of nurse aides while in training or competency evaluation.

- Costs of additional staff to replace nurse aides participating in training or competency evaluation.

- Continuing education or nurse aides following certification.

2. Additional Nurse Staff Requirements

Additional nurse staff required by a nursing facility to comply with the requirements of OBRA '87 will be reimbursed under the provisions of the Delaware Medicaid Patient Index Reimbursement System (PIRS). This system makes no distinction between levels of care for reimbursement. Nursing costs are derived from average hourly wage, benefit, and training cost data provided on the Nursing Wage Survey submitted by each facility. Prospective rates for each patient acuity classification are calculated by these costs by the minimum nursing time factors. Although representative of actual costs incurred, these prospectively determined rates are independent of the number employed or the number of staff vacancies at any given time.

3. Additional Non-Nursing Requirements

The Delaware Medicaid reimbursement system will recognize the incremental costs of additional staff and services incurred by nursing facilities to comply with the mandates of OBRA '87. Prospective rate calculations will be adjusted to account for costs incurred on or after October 1, 1990.

Where services are currently contracted by the nursing facility to a practitioner, additional services may be billed directly. These services are not covered by the rate component categories. This includes therapies, physician services, dental services, and prescription drugs.

A supplemental schedule to the Statement of Reimbursement Costs (Medicaid Cost Report) will be submitted by each facility to demonstrate projected staff and service costs required to comply with OBRA'87. For the rate year beginning October 1, 1990, facilities may project full year costs onto prior year reported actual costs to be included in the rate calculation.

The supplemental schedule will be used to project costs incurred for programs effective October 1, 1990 into the prospective reimbursement rates. Where nursing care facilities indicate new and anticipated staff positions, those costs will be included with the actual SFY '90 costs when calculating the reimbursement rates effective October 1, 1990.

Additional staff requirements include dietitian, medical director, medical records, activities personnel, and social worker.

H. Hold Harmless Provision

For the first year under the patient index reimbursement system the Department will have in effect a hold-harmless provision. The purpose of the provision is to give facilities an opportunity to adjust their operations to the new system. Under this provision, no facility will be paid less by Medicaid under the patient index system than it would have been paid had Federal Fiscal Year 1988 rates, adjusted by an inflation factor, been retained.

For the period October 1, 1990 to September 30, 1991, the Department will have in effect a hold-harmless provision with respect to capital reimbursement rates. The purpose of this provision is to give facilities an opportunity to adjust their operations to the new system. Under this provision, facilities will be paid the greater of the rate under the prospective capital rate methodology or the rate based on reimbursable costs. Beginning October 1, 1991, all facilities will be subject to the prospective capital rate methodology described in Section II.E.4.

V. RESIDENT'S RIGHTS

A. Resident Personal Funds: 8 hours/day x 1.5 days/mo x 12 mo/yr x $12.50/hr = $1,800 per year

- o Estimated 20 facilities will increase their bookkeeping staff to maintain records of interest bearing accounts, calculate interest, and produce quarterly statements.
- o Most likely approach to this requirement will be to employ temporary bookkeeping services.
- o Other facilities will absorb this requirement into their current bookkeeping staff.
- o This is the estimate of the Medicaid review nurse, who contacted a number of facilities to determine how this requirement would be met.

B. Other Resident's Rights:

The following patient's rights are not expected to result in additional costs for the nursing facilities:

1. Notice of Rights and Services
2. Rights of Incompetent Residents
3. Transfer and Discharge Rights
4. Access and Visitation Rights
5. Equal Access to Quality Care
6. Admissions Policy

No additional costs are anticipated for nursing facilities to implement other resident's rights. Most state regulations concerning specific patient's rights are the same as or more stringent than the Federal requirements. Those rights that are not addressed specifically as individual requirements in the state regulations, are protected by the Delaware's Patient's Bill of Rights.

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